December 11, 2015

Deputy Secretary Jennifer Burnett
Office of Long Term Living
Bureau of Policy and Regulatory Management
P.O. Box 8025
Harrisburg, PA 17105-8025

RE: Community HealthChoices Draft RFP and Program Requirements Comments

Submitted electronically via RA-MLTSS@pa.gov

Dear Secretary Burnett:

On behalf of the Center for Advocacy for the Rights and Interests of the Elderly (CARIE), thank you for the opportunity to provide comments regarding the Community HealthChoices (CHC) program draft Request for Proposal (RFP) and program requirements. We request that the comments we submitted for the Concept Paper be considered for this stage of the public comment process.

Founded in 1977, CARIE, is a non-profit advocacy organization working to improve the well-being, rights and autonomy of older adults. CARIE routinely helps older adults and their caregivers understand and resolve problems related to Medicare, Medicaid, and long term services and supports (LTSS). In addition, CARIE currently coordinates the PA-SMP program to help address fraud and serves as the local ombudsman for certain areas of Philadelphia. Through our work, we are acutely aware of the needs, issues and problems that older adults and their families encounter.

Draft CHC Request for Proposal (RFP) Comments

General Information

I-4. Problem Statement (pages 7-11)

CARIE continues to have major concerns with the timeline and the plan to fully implement the proposed Community HealthChoices (CHC) program statewide and recommends delaying the start date as well as limiting CHC to the SW region until problems are resolved. (The rationale for these concerns were highlighted in comments we submitted concerning the CHC Concept paper that we hope will be reviewed and considered.) The draft RFP and program requirements have not relieved our trepidations about the problems that will inevitably occur by moving too quickly through the planning process and implementing a program statewide before it is tested and modified on a smaller scale. If the Commonwealth continues this course, vulnerable consumers will no doubt be harmed as a result, despite the well-meaning intentions of the Department of Human Services (DHS). DHS should take the time needed to develop a well-conceived plan with a more realistic timetable for implementation. In recent years, there have been many examples of the state having disastrous outcomes implementing changes to its Medicaid Waiver program and this change is certainly of a much greater magnitude.
The Centers for Medicare & Medicaid Services (CMS) identifies adequate planning and transition strategies as an essential element for MLTSS programs. CMS advises, “The most effective MLTSS systems are the result of a thoughtful and deliberative planning process that permits enough time to develop a clear vision for the program. An adequate planning process includes the solicitation and consideration of stakeholder input; education of program participants; assessments of readiness at both the state and managed care plan level; and development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing implementation of MLTSS.” A recent Health Management Associates white paper, The Value of Medicaid Managed Care, echoes CMS’ recommendation, “States should thoughtfully plan RBMC (risk-based managed care) implementations, allowing time to build state infrastructure, define state contracting requirements and priorities, and ensure plan readiness.” Community Catalyst’s issue brief, Promising Practices for Medicaid Managed Long-Term Services and Supports, indicates “adequate planning” as a way for states to minimize risks and maximize benefits in MLTSS programs and further states that CMS recommends a minimum of a two-year planning process.

As proposed, CHC is scheduled to begin in the Southwest zone in slightly more than a year. Many details of the program need to be finalized and this should be done through a meaningful stakeholder process to have the best possible plan in place before a RFP is issued. Even disregarding having a thoughtful plan in place, DHS needs to issue a formal RFP, review proposals, negotiate rates with the MCOs, complete readiness reviews, and educate the public among other tasks. The managed care organizations (MCOs) will also have much to do to ramp-up and be prepared to serve the thousands of consumers in need of long-term services and supports (LTSS). The tasks at hand cannot be successfully or thoroughly completed by January 2017. One example of a state that rushed the process occurred when Florida began enrolling consumers into its MLTSS program and the MCOs were still in the process of developing their provider networks. This led to many serious problems for consumers. We are concerned that there is not enough time to ensure adequate provider networks in Pennsylvania.

We encourage Pennsylvania to pursue a MLTSS demonstration project as recommended by the Pennsylvania Long Term Care Commission. Ideally, Pennsylvania could test two different MLTSS models to see what works best in Pennsylvania and resolve any problems on a smaller scale before expanding statewide.

I-24. Term of Agreement (page 19)
CARIE strongly opposes DHS issuing the RFP for the entire state at one time. DHS should release a RFP for the SW zone as a start and later release another RFP for the remaining regions of the state once problems are identified and resolved so the subsequent RFP can reflect any needed changes. Even if this recommendation is disregarded, the proposed 5-year contract term for the SW zone and the 4-year contract term for the SE zone are far too long for a brand new, untested program. Any initial contract should be no longer than 2-3 years.

Work Statement Questionnaire
II-5. Work Statement and Work Statement Questionnaire: (Soundness and Approach) (pages 28-42)
One grave overall concern upon reviewing the draft RFP and program requirements is that too many details are left to the MCOs to develop. This is problematic for a variety of reasons. There is no meaningful way for consumers and other stakeholders to provide input, it is likely that there will be a
lack of consistency among the plans, and there will be inconsistent data making comparisons among plans and measuring the success of the program impossible. Hopefully, DHS will engage stakeholders to discuss and develop plans before a RFP is released so the responses to the questions asked throughout this section will be more to ensure the MCO has the capacity to comply with the program requirements.

The “Participant Service and Care Coordination” section of the work statement questionnaire that begins on page 29, only allows for a maximum of 30 pages. To get a needed level of detail, this maximum should be increased by at least 5 pages. Question 16 in this topic area should be expanded to include mental health. For example ask, “Describe your plan’s approach to identifying, reporting, and addressing social determinants of health and mental health for Participants.” Question 23 should be expanded to include participants “who do not speak English” and participants with “low literacy levels.”

The “Service Integration” section on pages 33-34 is confusing. Will Medicare and Medicaid be fully integrated? Questions should reflect different scenarios such as when a consumer chooses to receive their Medicare coverage through Original Medicare or Medicare Part C.

Questions should be added to have the MCOs explain how they will handle complaints, what provider information will be collected by the MCO and publically shared so participants can make informed choices about the best provider for them, as well as plans for marketing. MCOs should be required to describe their cultural competency plan. It is important to have a plan that ensures culturally and linguistically competent care and treatment for participants. Lesbian, gay, bisexual and transgender (LGBT) individuals and people living with HIV/AIDS often feel unwelcome at health or human services organizations and more needs to be done to ensure their inclusion and access to care. For consumers who opt out for their Medicare coverage, information should be gathered from MCOs as to how they will coordinate with Medicare’s hospice coverage and hospice drug coverage. This should include descriptions of how the MCO will help beneficiaries who need to transition out of Medicare hospice coverage.

**Draft CHC Program Requirements Comments**

Overall, while the draft CHS program requirements include some positive elements for consumers, we strongly believe that before a RFP is released more planning needs to occur that includes meaningful stakeholder input to discuss and develop the details needed to ensure positive outcomes. There are still many components of the plan that do not appear to be fully thought out which may mean even positive elements of the plan won’t be realized. It is important that all stakeholders have a clear understanding about what is being proposed, how the changes will be implemented, and how DHS plans to respond if a major crisis happens during implementation.

**Section V.A. - Covered Services (Page 26)**

This section references the CHC 1915(c) Waiver and illustrates a conundrum for stakeholders to provide meaningful input. DHS should develop its CHC 1915(c) Waiver before proceeding with releasing the RFP. It is important that stakeholders understand how the current 5 OLTL Waivers will be combined and what the criteria will be for getting LTSS. Regardless of how DHS proceeds, stakeholders should be given ample opportunity to provide comment on any CHC Waiver proposals before submission to CMS.
Section V.A.7. - Behavioral Health Services (Page 28-29)
Since counseling and therapy are covered LTSS services (per Exhibit DDD) and behavioral health services may also be provided through Medicare, this section should reflect the inclusion of needed behavioral health services that may not be provided by the BH-MCOs.

V.A.8. - Pharmacy Services (Page 29)
This section needs further clarification as not all full dual eligible participants who need prescriptions and over the counter medications will need LTSS or require a service plan. In addition, there is no reference to hospice in this section or in Exhibit BBB, Pharmacy Services. There is a need for coordination with the Medicare hospice benefit in that not all prescriptions needed by consumers are covered under the hospice benefit.

V.A.12. - Examinations to Determine Abuse or Neglect (pages 31-32)
MCOs should also know about the procedures for reporting financial exploitation in 12b.

V.A.13. - Hospice Services
Language should be added to require MCOs to coordinate with hospice services for those who choose to use Original Medicare or Medicare Part C.

V. A.17. - Nursing Facility Services (pages 33 and 34)
MCOs should not be allowed to force consumers to be admitted to a nursing facility if the cost of their care plan is equal or more than the cost of care in a nursing home. Once assessed as NFCE, consumers should be able to choose whether they want to receive their care in a nursing facility or at home. This option should be extended to family caregivers when the consumer lacks the capacity to make this decision.

V.A.18. - Participant Self-Directed Services (page 34)
Earlier this year, the Legislative Budget and Finance Committee issued a report, Family Caregivers in Pennsylvania’s Medicaid Home and Community-Based Waiver Programs, which documents a problem related to fraud and abuse that occurs at times in the Aging Waiver. The report concludes, “Paying family members to be caregivers can help overcome some of the challenges people face finding qualified, reliable, and continuous caregivers. However, family members often have access to financial and other personal data that would not generally be available to an agency-sponsored caregiver. There may also be a higher degree of trust between a beneficiary and a family member that could be exploited by an unscrupulous family caregiver. CMS requires states to take steps to address these issues, but family members are the largest category of financial exploiters of the elderly, so the concerns are warranted.”

It is important that MCOs are vigilant in monitoring the care of older consumers who choose to self-direct their services. There are some welfare-to work programs that encourage their clients to find an older person to take care of and this has led to consumers being neglected in some circumstances. Protocols need to be established to address situations when a caregiver is getting paid but is not providing services or if they are abusing, neglecting, or exploiting the consumer in other ways. There are situations where these circumstances would not involve OAPS intervention such as in cases where the consumer has capacity but refuses OAPS intervention. However, DHS and the MCO cannot
be complicit in the neglect of an older participant and other options should be implemented to allow the consumer to receive the care they need.

V.C. - Continuity of Care (pages 39-40)
If we interpret the first bullet point correctly, we strongly support DHS proposal to allow nursing facility residents to remain in the facility upon enrollment to CHC. This is particularly important to those who spend down their life savings, those whose rehabilitation stays become more permanent or longer than anticipated, and others who would otherwise need to endure transfer trauma. It should also be noted that federal and state law protects those who are residents of nursing homes from improper discharge. This should be monitored very closely.

In terms of continuity of care during the transition to CHC, it should be clear that no reductions along with the continuation of all services be provided for a minimum of 180 days. Any service reductions during the first year of each phase of the CHC rollout, must be reviewed by OLTL BEFORE notice is issued. (Appeal rights should still apply.)

V.E. - Needs Screening (page 40)
A participant, their family, or responsible party should be able to request a needs assessment at any time. It is encouraging to see that OLTL plans to develop a standardized needs screening tool. It is important to have a tested tool that provides consistent results throughout the state.

V.F. - Comprehensive Needs Assessments and Reassessments (pages 40-43)
It is important that DHS ensure both the medical and non-medical needs of consumers are met and there should be an equal focus on all needs in any MLTSS program. The MCO must demonstrate the capacity and protections to ensure that home and community-based services are treated equally with medical services and that the medical model not be used for home and community-based service planning and delivery.

The section states that the comprehensive needs assessment will be conducted by a Service Coordinator. It is important that the service coordinator is independent of the CHC-MCO to avoid conflict of interest.

OLTL should standardize the assessment and reassessment tools so all MCOs are required to use one uniform tool to ensure consistency and enable better data collection. Any tool should be tested to ensure validity and consistency throughout the state. It is vital that DHS ensure the transparency of the data collected and that it be shared with the public, especially in regard to cost, quality measurements and outcomes. Any algorithms used to authorize services should be made public so it is clear how any tool is used to determine eligibility and level of services as well as the number of service hours.

V.H. - Person-Centered Service Plans (PCSPs) (page 42-43)
The participant should be the lead in developing PCSPs and it should be clear that signing the plan only means they participated in the process and not that they necessarily agree with the plan.

PCSPs should also identify how the service coordinator will assist the participant in accessing covered services through their Medicare, BH-MCO and CHC-MCO identified in the PCSP.
There is no mention of veteran’s benefits throughout the draft documents. It is important that participants be screened and connected to any veteran’s benefits they may be entitled to receive.

It is also vital that PCSPs address the needs of participants with dementia and encourage their participation to the greatest extent possible. Participants and caregivers should be guided towards dementia capable services to help meet their needs.

V. I. - Department Review of Changes in Service Plans (page 43)
If DHS revises a PCSP, participants should still have the same appeal rights and notice as if the MCO made the decision.

V.K. - Service Coordinator and Service Coordinator Supervisor Requirements (page 44)
Service Coordinators and Service Coordinator Supervisors should be independent entities and not be employed by the MCOs to avoid any conflict of interest. They should also be required to demonstrate competency after completing DHS approved training. This could take the form of passing a post test.

O.2 - CHC-MCO Outreach Materials (page 46)
Outreach materials should meet the needs of those with low literacy levels.

O.4 - Limited English Proficiency (LEP) Requirements (page 50)
Interpreter services, including sign language, are expensive and should be a billable service for providers in the MCO network or paid for directly by the MCO.

V.O.14 - New Participant Orientation (page 54-55)
The CHC-MCOs written policies and procedures for new Participants or written orientation plan or program must also include more detailed information for Medicare beneficiaries so they understand their rights, how their benefits will be coordinated, and cost sharing benefits.

The handbook must also provide clear information to dual eligible members about Medicare and Medicaid and how their care will be coordinated.

V.Q - Additional Addressee (page 61)
This is a positive component of the proposal but should be expanded to develop protocols to allow Participants who may not be able to give consent the ability to have a responsible third party receive information. This would be particularly helpful for participants who have dementia.

V.R.1 - Participant Complaint, Grievance and Fair Hearing Process, page 62
Knowing that the transition to CHC will cause major disruptions and problems for consumers, it’s disappointing not to see any mention of an ombudsman program or any independent consumer advocate to assist consumers with problems and complaints.

Consumers should have access to an independent ombudsman as well as free legal services to help them through the grievance and appeal process. These procedures are critical particularly when
consumers are subject to service denials, reductions, and terminations. Without these resources, the process is stacked against the consumer.

It is important that CHC consumers have access to independent, free ombudsman services to help with issues such as understanding their rights, enrollment, accessing care, and appealing adverse decisions regarding their care. Ombudsman can also help identify systemic issues and should have access to state and MCO officials to resolve these problems in an expeditious manner.

It would be prudent to build upon Pennsylvania’s long term care ombudsman program rather than creating a new entity. Combining ombudsman services into the current program will be more cost effective, seamless for consumers regardless of how they may transition through settings or payers. Illinois is a state that has successfully combined its ombudsman program. It is important that any ombudsman program have adequate funding to be able to respond to the needs and concerns of MLTSS consumers. All consumers should receive information about ombudsman services upon enrollment, in any correspondence from the MCO or DHS about their plan or services and periodically throughout the year.

DHS should conduct focus groups with legal service providers and other advocates to develop the recommendations for a comprehensive grievance and appeals process. This process should be followed by an opportunity for all stakeholders to provide comments.

DHS and the public should receive regular data updates on the number of denials, appeals and grievances filed, and the decisions. Further data should be compiled and shared about the outcomes to those who were denied services.

All templates and other materials used to inform Participants about service denial decisions and the process to challenge those decisions should inform of their right to free legal help with complaints, grievances, and Fair Hearings.

V.Z. - Fraud and Abuse (pages 72-73)
DHS should have a verification system that prohibits any MCO or provider from participating in the CHC program that has or have owned a company that previously defrauded the government. If DHS is planning to reimburse providers based on a risk score (reimbursing health plans based on a calculated fee paying higher rates for sicker consumers) DHS needs to monitor for “upcoding” by plans. DHS also needs to monitor that consumers are receiving the services they are entitled to receive as there are incentives for MCOs to deny or limit services to keep their costs down.

V.EE. - QM and UM Requirements (pages 94-98)
Under the “Quality” heading on page 9 of the RFP and draft agreement summary, there is a reference to Exhibit GGG, “requires CHC-MCOs to report on an array of quality measures outlined in Exhibit GGG.” We could not find this exhibit but would recommend adding it and allowing for stakeholder input.

The lack of measures to help a consumer select a quality LTSS plan is a major problem. We hope that DHS will create a focus group to discuss what measures should be collected and how the data should be disseminated.
Exhibit L – Medical Assistance Transportation Program (page M(1)-3)
MCOs should also provide feeder information and support mobility management.

Exhibit LL – Guidelines for Sanctions Regarding Fraud and Abuse
The document refers to a Section VIII.H. SANCTIONS, but this section is not included. It is imperative that the Department have sanctions available for any violation of the Agreement that effects Participants.

Exhibit AAA - Provider Networks: Network Composition
DHS must establish and enforce clear standards to ensure all CHC-MCOs have an adequate network in place so consumers have real choice among qualified providers in all categories of service, that they or their caregivers will not have to travel excessive distances to access them, and that they will not have to wait for care due to a lack of provider capacity to serve their needs.

Exhibit DDD(2) - Covered Services
Participants should not receive funded services in Personal Care Homes under any circumstances.

Palliative care should be a covered service.

CARIE appreciates and supports the inclusion of “Pest Eradication” services.

Conclusion/Final Comments
CARIE hopes there will be more opportunities for feedback when more details are available and before decisions are finalized. We hope that Pennsylvania will create a thoughtful and deliberative state planning process and take the time needed to create a MLTSS system that promotes person-centered care, independence and dignity. The current timeline should be scrapped since it does not allow enough time to ensure meaningful consumer input, avert risks, optimize opportunities, or ensure a smooth transition for consumers. Stakeholder input should not be constrained by the procurement process. This historic change could be positive if all stakeholders are actively engaged in an ongoing, transparent process that includes significant discussion before formalizing or implementing any plan. DHS should continue to engage with stakeholders regularly in the monitoring and oversight of its MLTSS program. Should this process be instituted, CARIE is pleased to participate.

Thank you for the opportunity to provide comments. If you have any questions or need additional clarification, please contact Diane Menio at 267-546-3434 or menio@carie.org, or Kathy Cubit at 267-546-3438 or cubit@carie.org.

Respectfully Submitted,

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